FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0029397

Facility Name: New Way

Address: 80 Knupp School Lane (Number) Anna (City) 62906 (Zip Code)

County: Union

Telephone Number: 618 833-2299 **Fax #** 618 833-4993

IDPA ID Number: 371173155001

Date of Initial License for Current Owners: 3/11/86

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Richard Stroh **Telephone Number:** 618 833-5070 ext. 11

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Richard Stroh

(Title) Asst. Comptroller

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number New Way # 0029397 Report Period Beginning: 1/1/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 5840

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,251			5,251	13
14	TOTALS	5,251			5,251	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.91%

D. How many bed-hold days during this year were paid by the Department? 87 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1/16/2003

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 1/16/2003 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number New Way # 0029397 **Report Period Beginning:** 1/1/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	15,913	1,520	1,555	18,988		18,988		18,988			1
2	Food Purchase		37,272		37,272		37,272		37,272			2
3	Housekeeping		3,265	981	4,246		4,246	73	4,319			3
4	Laundry		651		651		651		651			4
5	Heat and Other Utilities			10,269	10,269		10,269	180	10,449			5
6	Maintenance		4,923	1,402	6,325		6,325	3,752	10,077			6
7	Other (specify):*											7
8	**TOTAL General Services**	15,913	47,631	14,207	77,751		77,751	4,005	81,756			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	186,529	4,073	12,949	203,551		203,551	887	204,438			10
10a	Therapy		501	6,068	6,569		6,569		6,569			10a
11	Activities			215	215		215		215			11
12	Social Services	1,704	1,470	963	4,137		4,137	(1,286)	2,851			12
13	CNA Training	2,167		735	2,902		2,902		2,902			13
14	Program Transportation		4,757	2,681	7,438		7,438	279	7,717			14
15	Other (specify):* **Day Training**			163,878	163,878		163,878	(163,878)				15
16	**TOTAL Health Care and Programs**	190,400	10,801	187,489	388,690		388,690	(163,998)	224,692			16
	C. General Administration											
17	Administrative	40,042		9,600	49,642		49,642	4,349	53,991			17
18	Directors Fees							130	130			18
19	Professional Services			25,370	25,370		25,370	(23,759)	1,611			19
20	Dues, Fees, Subscriptions & Promotions			1,687	1,687		1,687	(252)	1,435			20
21	Clerical & General Office Expenses		1,793	6,149	7,942		7,942	7,876	15,818			21
22	Employee Benefits & Payroll Taxes			33,285	33,285		33,285	4,485	37,770			22
23	Inservice Training & Education			9	9		9		9			23
24	Travel and Seminar			60	60		60	5	65			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			1,962	1,962		1,962	157	2,119			26
27	Other (specify):*											27
28	**TOTAL General Administration**	40,042	1,793	78,122	119,957		119,957	(7,009)	112,948			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	246,355	60,225	279,818	586,398		586,398	(167,002)	419,396			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number New Way #0029397 **Report Period Beginning:** 1/1/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			16,848	16,848		16,848	(771)	16,077			30
31	Amortization of Pre-Op. & Org.			512	512		512		512			31
32	Interest			11,449	11,449		11,449	(9,951)	1,498			32
33	Real Estate Taxes			5,613	5,613		5,613	126	5,739			33
34	Rent-Facility & Grounds							479	479			34
35	Rent-Equipment & Vehicles							205	205			35
36	Other (specify):* **See Pg 24**			23,884	23,884		23,884	(23,884)				36
37	**TOTAL Ownership**			58,306	58,306		58,306	(33,796)	24,510			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			32,562	32,562		32,562		32,562			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			32,562	32,562		32,562		32,562			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	246,355	60,225	370,686	677,266		677,266	(200,798)	476,468			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number New Way # 0029397 Report Period Beginning: 1/1/05 Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$ (163,878)	15	$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,673)	30		9
10	Interest and Other Investment Income	(25)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(9,926)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(200)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(7,402)	36		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(16,482)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(1,409)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (200,995)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	197		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 197		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (200,798)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

New Way

ID# 0029397

Report Period Beginning: 1/1/05

Ending: 12/31/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	PAC Dues	$ (73)	20	1
2	Chamber Dues	(50)	20	2
3	Clothing	(1,186)	12	3
4	Entertainment	(100)	12	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,409)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number New Way # 0029397 **Report Period Beginning:** 1/1/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	73	0	0	0	0	0	0	0	0	0	73	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	180	0	0	0	0	0	0	0	0	0	180	5
6	Maintenance	0	186	3,566	0	0	0	0	0	0	0	0	3,752	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	439	3,566	0	0	0	0	0	0	0	0	4,005	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	887	0	0	0	0	0	0	0	0	887	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	(1,286)	0	0	0	0	0	0	0	0	0	0	(1,286)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	279	0	0	0	0	0	0	0	0	0	279	14
15	Other (specify):*	(163,878)	0	0	0	0	0	0	0	0	0	0	(163,878)	15
16	**TOTAL Health Care and Programs**	(165,164)	279	887	0	0	0	0	0	0	0	0	(163,998)	16
	C. General Administration													
17	Administrative	0	0	4,349	0	0	0	0	0	0	0	0	4,349	17
18	Directors Fees	0	130	0	0	0	0	0	0	0	0	0	130	18
19	Professional Services	0	241	(24,000)	0	0	0	0	0	0	0	0	(23,759)	19
20	Fees, Subscriptions & Promotions	(323)	71	0	0	0	0	0	0	0	0	0	(252)	20
21	Clerical & General Office Expenses	0	1,233	6,643	0	0	0	0	0	0	0	0	7,876	21
22	Employee Benefits & Payroll Taxes	0	4,485	0	0	0	0	0	0	0	0	0	4,485	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	5	0	0	0	0	0	0	0	0	0	5	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	157	0	0	0	0	0	0	0	0	0	157	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(323)	6,322	(13,008)	0	0	0	0	0	0	0	0	(7,009)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(165,487)	7,040	(8,555)	0	0	0	0	0	0	0	0	(167,002)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number New Way **#** 0029397 **Report Period Beginning:** 1/1/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(1,673)	0	902	0	0	0	0	0	0	0	0	(771)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,951)	0	0	0	0	0	0	0	0	0	0	(9,951)	32
33	Real Estate Taxes	0	126	0	0	0	0	0	0	0	0	0	126	33
34	Rent-Facility & Grounds	0	479	0	0	0	0	0	0	0	0	0	479	34
35	Rent-Equipment & Vehicles	0	0	205	0	0	0	0	0	0	0	0	205	35
36	Other (specify):*	(23,884)	0	0	0	0	0	0	0	0	0	0	(23,884)	36
37	**TOTAL Ownership**	(35,508)	605	1,107	0	0	0	0	0	0	0	0	(33,796)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(200,995)	7,645	(7,448)	0	0	0	0	0	0	0	0	(200,798)	45

Facility Name & ID Number New Way # 0029397 Report Period Beginning: 1/1/05 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Don J. Pippins	98	Liberty House	Marion	ILS 1-3	Anna	CILA
Victor Metzger	2	Holly Hill	Anna	ILS 4	Metropolis	CILA
		Lincoln Square	Jonesboro	JR's Centre	Anna	Workshop
		Pilot House	Cairo	kel-Tech Management	Anna	Mgmt Co.
		Krypton	Metropolis			
		Glen Brook	Vienna			
		Mulberry Manor	Anna			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	3	Housekeeping	$	kel-Tech Management Co.	25.00%	$ 73	$ 73	1
2	V	5	Utilities		kel-Tech Management Co.	25.00%	180	180	2
3	V	6	Maintenance		kel-Tech Management Co.	25.00%	186	186	3
4	V	14	Transportation		kel-Tech Management Co.	25.00%	279	279	4
5	V	18	Director's Fees		kel-Tech Management Co.	25.00%	130	130	5
6	V	19	Professional Services		kel-Tech Management Co.	25.00%	241	241	6
7	V	20	Dues, Fees & Subscriptions		kel-Tech Management Co.	25.00%	71	71	7
8	V	21	Office Expenses		kel-Tech Management Co.	25.00%	1,233	1,233	8
9	V	22	Employee Benefits		kel-Tech Management Co.	25.00%	4,485	4,485	9
10	V	24	Seminar		kel-Tech Management Co.	25.00%	5	5	10
11	V	26	P & C Insurance		kel-Tech Management Co.	25.00%	157	157	11
12	V	33	Real Estate Taxes		kel-Tech Management Co.	25.00%	126	126	12
13	V	34	Building Lease		kel-Tech Management Co.	25.00%	479	479	13
14	Total			$			$ 7,645	$ * 7,645	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number New Way # 0029397 Report Period Beginning: 1/1/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	Equipment Lease	$	kel-Tech Management Co.	25.00%	$ 205	$ 205	15
16	V	10	Nursing		kel-Tech Management Co.	25.00%	887	887	16
17	V	17	Administration		kel-Tech Management Co.	25.00%	4,349	4,349	17
18	V	21	Clerical		kel-Tech Management Co.	25.00%	6,643	6,643	18
19	V	6	Maintenance		kel-Tech Management Co.	25.00%	3,566	3,566	19
20	V	19	Professional Services	24,000	kel-Tech Management Co.	25.00%		(24,000)	20
21	V	30	Depreciation		kel-Tech Management Co.	25.00%	902	902	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 24,000			$ 16,552	$ * (7,448)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number New Way # 0029397 Report Period Beginning: 1/1/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Don J. Pippins	Administrator	Administrator	98.00	61,243	8	20.00	ADM	$ 40,042	17-1	1
2	Victor Metzger	RSD	RSD	2.00		40	100.00	RSD	56,711	10-1	2
3	Charlotte Metzger		Program Staff					Program Staff	16,505	10-1	3
4	Diana Alley		Nurse		51,294	1.5	3.75	Nursing	965	10-1	4
5											5
6											6
7	kel-Tech Mgmt Co. Allocation:										7
8	Diana Alley							Nursing	887		8
9	Jacob Alley							Maint.	3,566		9
10	James A. Keller							Administration	4,349		10
11											11
12											12
13								TOTAL	$ 123,025		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number New Way # 0029397 Report Period Beginning: 1/1/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: kel-Tech Management Co.
Street Address: 158 E. Vienna Street
City / State / Zip Code: Anna, IL 62906
Phone Number: (618 833-5070
Fax Number: (618 833-4993

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	Mgmt Fee Contributin	360,999	12	$ 1100.04	$	24,000	$ 73	1
2	5	UTILITIES ELECT/GAS	Mgmt Fee Contributin	360,999	12	2,401		24,000	160	2
3	5	UTILITIES WATER-B	Mgmt Fee Contributin	360,999	12	309		24,000	21	3
4	6	GROUNDS MAINT	Mgmt Fee Contributin	360,999	12	416		24,000	28	4
5	6	MAINTENANCE SUPPLIES	Mgmt Fee Contributin	360,999	12	245		24,000	16	5
6	6	MAINTENANCE VEHICLE	Mgmt Fee Contributin	360,999	12	119		24,000	8	6
7	6	PREVENTATIVE MAINT	Mgmt Fee Contributin	360,999	12	99		24,000	7	7
8	6	REPAIRS BLDG	Mgmt Fee Contributin	360,999	12	90		24,000	6	8
9	6	REPAIRS FURN/EQUIP	Mgmt Fee Contributin	360,999	12	1,830		24,000	122	9
10	14	REPAIRS VEHICLES	Mgmt Fee Contributin	360,999	12	246		24,000	16	10
11	14	TRANSPORTATION	Mgmt Fee Contributin	360,999	12	3,953		24,000	263	11
12	18	DIRECTOR'S FEES	Mgmt Fee Contributin	360,999	12	1,950		24,000	130	12
13	19	LEGAL & ACCOUNTING	Mgmt Fee Contributin	360,999	12	3,625		24,000	241	13
14	20	DUES FEES SUBSCRIPTIONS	Mgmt Fee Contributin	360,999	12	1,061		24,000	71	14
15	21	EDUCATIONAL SUPPLIES	Mgmt Fee Contributin	360,999	12	45		24,000	3	15
16	21	BANK CHARGES	Mgmt Fee Contributin	360,999	12	64		24,000	4	16
17	21	COPIER EXPENSE SUPPLIES	Mgmt Fee Contributin	360,999	12	243		24,000	16	17
18	21	COPIER EXPENSE SERVICE C	Mgmt Fee Contributin	360,999	12	475		24,000	32	18
19	21	G & A MISC	Mgmt Fee Contributin	360,999	12	484		24,000	32	19
20	21	SUPPLIES STOCK	Mgmt Fee Contributin	360,999	12	793		24,000	53	20
21	21	G & A SUPPLIES	Mgmt Fee Contributin	360,999	12	9,132		24,000	607	21
22	21	POSTAGE	Mgmt Fee Contributin	360,999	12	2,525		24,000	168	22
23	21	SOFTWARE EXPENSE	Mgmt Fee Contributin	360,999	12	825		24,000	55	23
24	21	TELEPHONE	Mgmt Fee Contributin	360,999	12	2,400		24,000	160	24
25	TOTALS					$ 34,429	$		$ 2,292	25

Facility Name & ID Number New Way # 0029397 Report Period Beginning: 1/1/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: kel-Tech Management Co.
Street Address: 158 E. Vienna Street
City / State / Zip Code: Anna, IL 62906
Phone Number: (618 833-5070
Fax Number: (618 833-4993

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	CELL PHONE EXPENSE	Mgmt Fee Contributin	360,999	12	$ 1159.34	$	24,000	$ 77	1
2	21	UTILITIES-INTERNET	Mgmt Fee Contributin	360,999	12	408		24,000	27	2
3	22	INS EMP GROUP	Mgmt Fee Contributin	360,999	12	43,812		24,000	2,913	3
4	22	INSURANCE W/C	Mgmt Fee Contributin	360,999	12	3,770		24,000	251	4
5	22	PAYROLL TAX EXPENSE	Mgmt Fee Contributin	360,999	12	19,880		24,000	1,322	5
6	24	ADM. STAFF TRAINING	Mgmt Fee Contributin	360,999	12	79		24,000	5	6
7	26	INSURANCE BLDG & LIAB	Mgmt Fee Contributin	360,999	12	1,123		24,000	75	7
8	26	INSURANCE VEHICLES	Mgmt Fee Contributin	360,999	12	1,245		24,000	83	8
9	33	REAL ESTATE TAXES	Mgmt Fee Contributin	360,999	12	1,893		24,000	126	9
10	34	LEASE BLDG	Mgmt Fee Contributin	360,999	12	7,200		24,000	479	10
11	35	LEASE EQUIP	Mgmt Fee Contributin	360,999	12	3,076		24,000	205	11
12	10	NURSING WAGES	Mgmt Fee Contributin	360,999	12	13,341	13,341	24,000	887	12
13	17	ADMINISTRATION WAGES	Mgmt Fee Contributin	360,999	12	65,419	65,419	24,000	4,349	13
14	21	CELRICAL WAGES	Mgmt Fee Contributin	360,999	12	99,921	99,921	24,000	6,643	14
15	6	MAINTENANCE WAGES	Mgmt Fee Contributin	360,999	12	53,640	53,640	24,000	3,566	15
16	30	DEPRECIATION	Mgmt Fee Contributin	360,999	12	13,569		24,000	902	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 329,536	$ 232,321		$ 21,910	25

Facility Name & ID Number New Way # 0029397 Report Period Beginning: 1/1/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Banterra Bank		X	Equipment Purchase	$360.89	1/16/03	$ 28,162	$ 15,819	12/2009	6.0000	$ 1,162	1
2	Anna National Bank		X	Real Estate Mortgage	$2,759.06	1/1986	327,500			7.0000	361	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$3,119.95		$ 355,662	$ 15,819			$ 1,523	9
	B. Non-Facility Related*											
10	Mary Hardesty		X	Stock Repurchase	$284.00	1/2003	57,917	47,430	12/2017	5.0000	3,293	10
11	Pat Lewis		X	Stock Repurchase	$962.00	1/2003	109,833	95,530	12/2017	5.0000	6,633	11
12												12
13												13
14	TOTAL Non-Facility Related				$1,246.00		$ 167,750	$ 142,960			$ 9,926	14
15	TOTALS (line 9+line14)						$ 523,412	$ 158,779			$ 11,449	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number New Way # 0029397 **Report Period Beginning:** 1/1/05 **Ending:** 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.	***Important*** **,** please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 4,850	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 5,163	2
3. Under or (over) accrual (line 2 minus line 1).		$ 313	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 5,300	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 5,613	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	4,628	8
	2001	4,710	9
	2002	4,725	10
	2003	4,785	11
	2004	5,163	12

	FOR OHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2004	$		13
14	PLUS APPEAL COST FROM LINE 5	$		14
15	LESS REFUND FROM LINE 6	$		15
16	AMOUNT TO USE FOR RATE CALCULATION	$		16

Sch V, Line 33, col. 8	5739
kel-Tech Mgmt Co Alloc	-126
Sch IX, Line 7	5613

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME New Way COUNTY Union

FACILITY IDPH LICENSE NUMBER 0029397

CONTACT PERSON REGARDING THIS REPORT Richard Stroh

TELEPHONE 618 833-5070 FAX #: 618 833-4993

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-29-04-014	S29 T12 R1W	$ 5,163.34	$ 5,163.34
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 5,163.34	$ 5,163.34

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number New Way # 0029397 Report Period Beginning: 1/1/05 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 5,556 B. General Construction Type: Exterior Alum. Siding & Brick Frame Wood Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 2,588
2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 512
4. Dates Incurred: 1/1/03

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Healthcare	43,560	1984	$ 10,000	1
2					2
3	TOTALS	43,560		$ 10,000	3

Facility Name & ID Number New Way # 0029397 Report Period Beginning: 1/1/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16			1985	$ 298,575	$ 8,610	40	$ 8,610	$	$ 164,312	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Siding & Guttering			2003	8,200	491	15	547	56	3,783	9
10	Painting			2003	3,558	213	15	356	143	1,642	10
11	Carpet			2003	4,259		7	608	608	4,259	11
12	Bathroom Flooring/Fixture			2004	1,364		7	195	195	1,364	12
13	Clooring			2004	2,274		7	325	325	2,274	13
14	Flooring			2004	1,699		7	243	243	1,699	14
15	Blinds			2004	1,568		7	224	224	1,568	15
16	Water Softners			2005	1,344	1,344	7	72	(1,272)	1,344	16
17	Security Alarm			2005	875	7	7	7		7	17
18	Bedroom Addition			2003	2,145	128	15	143	15	990	18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number New Way # 0029397 Report Period Beginning: 1/1/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 325,861	$ 10,793		$ 11,330	$ 537	$ 183,242	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number New Way # 0029397 Report Period Beginning: 1/1/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$	$	$	$		$	71
72	Current Year Purchases	4,280	4,280	77	(4,203)	7	4,280	72
73	Fully Depreciated Assets	187,272		3,040	3,040	7	187,272	73
74								74
75	TOTALS	$ 191,552	$ 4,280	$ 3,117	$ (1,163)		$ 191,552	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Healthcare	1999 Mercury Mountaineer	1999	$ 21,567	$ 1,775	$ 728	$ (1,047)	5	$ 17,858	76
77										77
78										78
79										79
80	TOTALS			$ 21,567	$ 1,775	$ 728	$ (1,047)		$ 17,858	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 548,980	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 16,848	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 15,175	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (1,673)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 392,652	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number New Way # 0029397 Report Period Beginning: 1/1/05 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description: (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number New Way # 0029397 Report Period Beginning: 1/1/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [X] YES
   - [ ] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM: [X]
   - IN OTHER FACILITY: [ ]
   - COMMUNITY COLLEGE: [ ]
   - HOURS PER CNA: 44

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM: [X]
   - IN OTHER FACILITY: [ ]
   - HOURS PER CNA: 86

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)		735		735
4	Clinical Wages (b)		1,432		1,432
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments		735		735
8	CNA Competency Tests				
9	TOTALS	$	$ 2,902	$	$ 2,902
10	SUM OF line 9, col. 1 and 2 (e)	$ 2,902			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	3
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	3

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number New Way # 0029397 Report Period Beginning: 1/1/05 Ending: 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/05 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 82,964	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	72,281		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	111,391		8
9	Other(specify): Emp Adv	8		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 266,644	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	10,000		13
14	Buildings, at Historical Cost	298,575		14
15	Leasehold Improvements, at Historical Cost	27,286		15
16	Equipment, at Historical Cost	213,120		16
17	Accumulated Depreciation (book methods)	(392,652)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	2,558		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(1,536)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 157,351	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 423,995	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 6,500	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	10,325		30
31	Accrued Taxes Payable (excluding real estate taxes)	(8,016)		31
32	Accrued Real Estate Taxes(Sch.IX-B)	5,300		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 14,109	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	206,280		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 206,280	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 220,389	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 203,606	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 423,995	$	48

***(See instructions.)**

Facility Name & ID Number New Way **#** 0029397 **Report Period Beginning:** 1/1/05 **Ending:** 12/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 172,195	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 172,195	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	31,411	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 31,411	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 203,606	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number New Way # 0029397 Report Period Beginning: 1/1/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 528,029	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 528,029	3
	B. Ancillary Revenue		
4	Day Care	176,190	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 176,190	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	4,433	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 4,433	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	25	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 25	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 708,677	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	77,751	31
32	Health Care	388,690	32
33	General Administration	119,957	33
	B. Capital Expense		
34	Ownership	58,306	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	32,562	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 677,266	40
41	**Income before Income Taxes (line 30 minus line 40)****	31,411	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 31,411	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number New Way # 0029397 Report Period Beginning: 1/1/05 Ending: 12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	40	40	965	24.13	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	200	200	1,704	8.52	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,813	1,898	15,913	8.38	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers					18
19	Laundry					19
20	Administrator	520	520	40,042	77.00	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,961	2,082	56,711	27.24	29
30	Habilitation Aides (DD Homes)	15,560	16,326	131,020	8.03	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	20,094	21,066	$ 246,355 *	$ 11.69	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	36	$ 1,555	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	210	10,500	10-3	38
39	Pharmacist Consultant	21	850	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	33	1,958	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	27	963	12-3	45
46	Other(specify) Dental Consultant	12	1,200	10-3	46
47	Administrator Consultant	128	9,600	17-3	47
48	Psychologist/Psychiatric Consultant	55	4,110	10a-3	48
49	TOTAL (lines 35 - 48)	522	$ 30,736		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number New Way # 0029397 Report Period Beginning: 1/1/05 Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Don J. Pippins	Admin	98	$ 40,042
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 40,042

B. Administrative - Other

Description	Amount
Connie Dodson	$ 9,600
TOTAL (agree to Schedule V, line 17, col. 3)	$ 9,600
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
kel-Tech Management Co	Accting/Mgmt	$ 24,000
Barnett & Levine	CPA Services	965
FMGR	Legal Services	405
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 25,370

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 4,618
Unemployment Compensation Insurance	4,220
FICA Taxes	18,380
Employee Health Insurance	5,867
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employment Physicals	200
kel-Tech Mgmt Co. Alloc.	4,485
TOTAL (agree to Schedule V, line 22, col.8)	$ 37,770

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 10)	160
kel-Tech Mgmt Alloc.	71
Sam's Mem/Subscrip/Surety Bond	367
IL Healthcare Assoc Dues	837
*PAC Dues	73
*Chamber Dues	50
*Non-Allowables	(123)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,435

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
SIU DD & Mental Health Conf.	60
kel-Tech Mgmt Alloc.	5
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 65

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number New Way # 0029397 Report Period Beginning: 1/1/05 Ending: 12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number New Way # 0029397 **Report Period Beginning:** 1/1/05 **Ending:** 12/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Healthcare Assoc. $837**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **145** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **32,562**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain. **Not required of the facility.**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

New Way, Inc.
Reconciliation of Sch. V, line 30, Col. 8 to Sch. XI, Line 83, Col. 6
2005

Sch. XI, Line 83, Col. 6	$ 15,175.00
kel-Tech Allocation	902.00
Sch. V, Line 30, Col. 8	$ 16,077.00

New Way, Inc.
Reconciliation of Book to Tax Income
2005

Adjusted book income	$ 31,410.00
Adjustment for accrual changes from 1/1/05 to 12/31/05	37,744.00
Add provision for federal income taxes	11,258.00
Taxable income per federal income tax return	$ 80,412.00

New Way, Inc.
Analysis of Sch. V, Line 36, Col. 4
2005

Bad Debt	$ 7,402.00
Federal Income Tax	11,258.00
State Income Tax	5,224.00
	$ 23,884.00

Related Parties Schedule VII
Owners Compensation
Jan 1, 2005 - Dec 31, 2005

	Totals / Entity	Holly Hill	ILS 1-4	JR's Centre	Mulberry Manor	Pilot House	Liberty House	Lincoln Square	kel-Tech Mgmt	Krypton	Glen Brook	New Way
Don Pippins	$ 134,362	11,964	11,077	22,000			6,000			43,279		40,042
Denise Pippins	$ 87,416	25,964	21,058	40,394								
Diana Alley	$ 103,421	11,964	28,221	9,600	15,300			24,030	13,341			965
Jo Ann Keller	$ 140,988			14,923	102,000	24,065						
James K. Keller	$ 29,323			14,923	14,400							
Jacob Alley	$ 50,613								50,613			
Jake Alley	$ 39,594		36,994		2,600							
James A. Keller	$ 97,265		20,493						65,419		11,353	
	$ 682,982	$ 49,892	$ 117,843	$ 101,840	$ 134,300	$ 24,065	$ 6,000	$ 24,030	$ 129,373	$ 43,279	$ 11,353	$ 41,007